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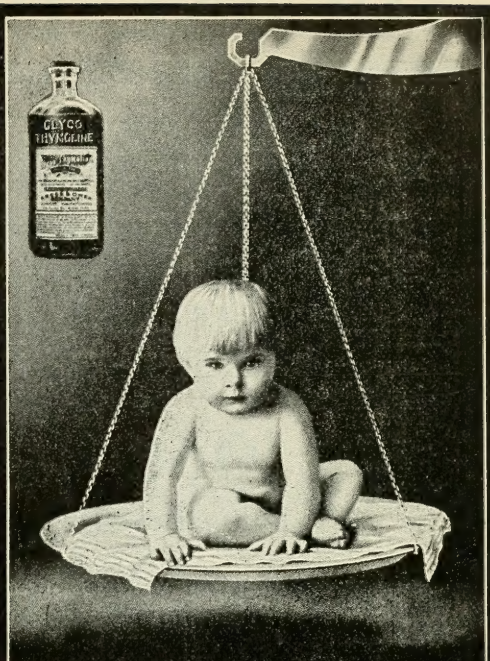

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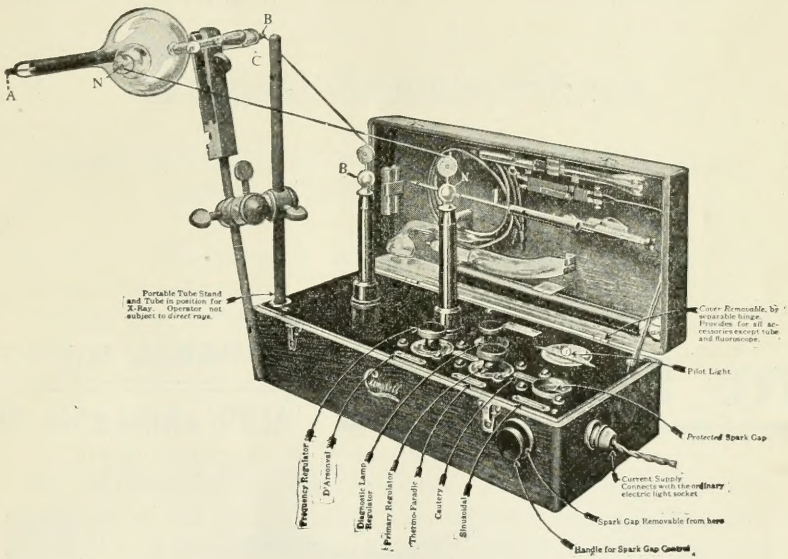

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NASHVILLE JOURNAL
— OF —
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVIII. SEPTMBER, 1914. No. 9

Original Communications

CHRONIC VISCERAL PAIN IN RELATION TO SURGERY AND PSYCHOTHERAPY.

By Tom A. Williams, M. B., C. M. (Edin), Washington, D. C.
Pres. Nat. Soc. Ment. and Nervous Diseases; Memb. Corresp. Socs. de Neurol. et Psychol. de Paris; M. Am. Psychopathological Asso., Etc., Neurologist to Epiphany Free Dispensary.

American surgeons and gynecologists have at last decided almost unanimously that the "neurasthenia" accompanied by viscera ptosis is not at all benefited by operative replacement. But Dr. Mayo (Congress of American Physicians and Surgeons), May, 1910, confesses himself at a loss what to do with such patients; as most of them were sent him by neurologists, who had failed to relieve their suffering. He tnought that something like Christian Science might be the best thing. Only a few week's ago, indeed, a United States Senator, in seeking against the proposal to unify all present Federal medical agencies, pleaded dramatically for the cult which had restored to health his wife and self, invalids of long standing, whom doctors had failed to improve, and his son, a dipsomaniac, with whom also regular doctors had failed.

But the answer to Dr. Mayo's question is not a negation of the facts of the world like Christian Science, but a measure based

upon rational psychology and a grasp of the genesis of hysterical fixed ideas, and psychasthenic obsessions and phobias. The following cases show the simplicity of the procedure when the principles of diagnosis and treatment are understood, and that as Trissand said, to use training before rather than after an operation.

Hysterical Appendicitis of three Months' Standing Cured by Psychotherapeutics After Failure of Surgery.

Case 1—(girl of 20 years was referred by Dr. Watkins and Dr. Stavely because of recurrences of right iliac pain with nausea and vomiting, but with normal temperature and pulse, since three months. Two months before, the appendix had been removed for similar symptoms, and found little changed, though containing a concretion of lime. At the time, the ovaries and gallbladder were found normal. The pains recurred every few days and lasted some hours, and were relieved by morphine or the Scotch douch. Examination showed only a psychogenic hyperesthesia in the right iliac fossa, controllable by indirect suggestion. Some colonic atonia, a slight retroversion and intestinal sand could not explain a manifestly psychogenic tenderness. So, after a few days, Dr. Watkins, armed by conviction derived from the consultation, entered the fray, and after a struggle of nearly two hours convinced the young woman that determination to conquer a longing for the comforting and anodynes which sickness brings would cure her. She went back to Illinois next day, and remains well.

Such rapid success is not common. The following similar case illustrates the need of persistence in persuasion.

Coccygodynic Neurasthesia from Hernia.

A girl of 34 years was referred by Dr. Lemon because unbenefited by uterine suspension, amputation of the coccyx and other gynecological measures. She was lying stiffly in bed for fear of hurting the coccyx, with intense right iliac pain and tenderness. I found the latter modifiable by suggestion, as was the stiffness.

There was a false, i. e., volitional Kernig's sign; and the reflexes were sluggish. She wore the martyr smile but professed anxiety to recover and go to work.

Her condition was manifestly psychogenetic, but her sister's belief in its organic nature hindered recovery, in spite of the persistency of Dr. Lemon. But, at my instigation, he kept persuading, until finally improvement began, and one day the young woman, determined to put it to the proof, went to work, succeeded in the fierce struggle against giving way, and is now more capable than she has ever been before.

Hysterical Spasm from Appendicitis; Secondary Neurasthenia. Cure in Two Weeks by Re-education.

Case III—A case, intermediate as to duration of treatment, was seen recently with Dr. I. S. Stone. The patient had had a dull pain since an attack of appendicitis six years before, but had gone on working in her dairy in spite of it, until it wore her out. After this, a spasm of the iliac muscles supervened. She declared herself nervous because she suffered so intensely. She would start at noises, and could not sleep after excitement; so she gave up visiting her friends. The only neurological signs were the hyperæsthesia and spasmodicity in the right iliac region.

I taught her to inhibit the spasm by drill, and assured her that the hyperæsthesia would disappear as a result of the operation which Dr. Stone had performed three weeks before. But as the spasm had become a habit, and gave rise to pain by stretching the muscles, she would have to learn to control it by means of a series of exercises in muscular inhibition, which I showed her to perform. She made quick progress at first, but relapsed on account of a physical depression, which I found to be due to disordered metabolism from the egg and milk diet which the recumbent posture did not enable her to metabolize. When this was rectified, the psycho-motor discipline was again persevered with, and she returned home, almost well, two weeks after I saw her.

Of course, the key to each case is that the physician have a clear notion of the mechanism of hysterical fixed ideas, of which the idea of pain and tenderness is not the least frequent.

Still the technique of psychotherapy is not hard to achieve *after psychopathological data have been acquired.* But to attempt psychotherapy without knowing to what it is being applied is as fatuous as the grossest empiricism in any other part of medical or surgical art.

"Just as the surgeon requires, first, a minute knowledge of anatomy and pathology; second, the good sense to apply this knowledge clinically; third, acquaintance with and a practice of technical advances in his art; so the psychotherapeutist requires first, a minute knowledge of psychology and psychopathology (I exclude all metaphysical notions, which unfortunately are rife in much of which has been written on psychological medicine); second, the acumen to use this knowledge clinically in diagnosis; and third, the acquaintance with and the practice of technical procedures as they improve."—*Physiological Measures in the Treatment of Nervous Diseases, American Journal of Psychological Therapeutics,* January, 1911.

As the cases show, the principle of the treatment is to teach the patient to use the disabled part in spite of the tenderness excited. This requires training; and it is the doctor's duty to give it himself or through a nurse. Of course discretion must be used not to apply this treatment to the pain of active inflammation. Again, there are times when a patient should not be urged, such as case three shows. It is in such contingencies that lay psychotherapy is palpably defective. I can not here enter further even into the principles which should guide the physician as to when to urge and when to rest the patient. Psychological tact and experience can hardly be inculcated in a short space. The reader who is interested may consult *Nursing for Neurologist, The Trained Nurse and The Hospital Review* for June, 1910; also cases showing the origin of Hysterical and Pseudo Hysterical Symptoms, *American Journal Medical New.*, August 9, 1910; *Forthnesing Treatment of Hysteria, Jour. Nerv. and Ment. Dis.*, 1758.

W. W.

Proceedings of Societies

AMERICAN PROCTOLOGIC SOCIETY.

Sixteenth Annual Meeting, Held at Atlantic City, N. J., June 22 and 23, 1914.

"Extracts from the Report of Proctologic Literature from March, 1913, to March, 1914."—By Samuel T. Earle, M.D., of Baltimore, Md.

In Samuel T. Earle's review of Proctologic Literature from March, 1913, to March, 1914, he quotes from the following authors, giving the salient points from each of their papers:

Percival P. Cole, M.B., Ch. B. F. R. C. S. England (British Medical Journal, Vol. I, 1913, page 431) "The Intramural Spread of Rectal Carcinoma."

Robert A. Bachman, M.D., Newport, R. I., Surgeon U. S. Navy. (Journal of American Medical Association, Vol. L., 1913, page 1154.) "A New Method for Hemorrhoids."

Jerome M. Lynch, M.D., New York City. (The American Journal of Obstetrics and Diseases of Children, February, 1914, page 322.) "Blocking the Sympathetic by a Method Other than Spinal Anesthesia to prevent shock in the combined operation for Cancer of the Rectum, or Recto-Sigmoidal Juncture, with some Improvements and Modifications of Technic."

Charles R. Robins, M.D., Richmond, Va. (The Old Dominion Journal of Medicine and Surgery, May, 1913, Vol. XVI, page 236.) "Sliding the Rectum in the Cure of Various Defects."

Granville S. Hanes, M. D., Louisville, Ky. (Kentucky Medical Journal, Vol. XI, June 25, 1913, page 516.) "Anal Pruritus Treated by Operation; Report of Case."

Frederick H. Williams, M.D., Boston, Mass. (New York Medical Journal, Vol. XCVII, 1913, page 875.) "Electricity in Rectal Diseases. A Neglected Resource in their Treatment."

T. F. Riggs, M.D., Pierre, S. D. (The St. Paul Medical Journal, Vol. XV, page 461.) "Fistula-in-Ano; Its Rational and Successful Treatment."

P. Lockhart Mummery, F. R. C. S. England. (The Lancet, Vol. II, 1913, page 72.) "Operation and After-Treatment of Fistula-in-Ano."

Harvey B. Stone, M.D., Baltimore, Md. (Annals of Surgery, Vol. XVIII, 1913, page 647.) "Immediate and Late Results of the Whitehead Operation for Hemorrhoids."

Daniel Fisk Jones, M.D., Boston, Mass. (Boston Medical and Surgical Journal, Vol. CLXIX, page 707.) "Carcinoma of the Rectum."

James W. Heslop, M. B., M. R. C. S., New Castle-on--Tyne, England. (The British Medical Journal, February 28, 1914, page 476.) "Dissemination in Carcinoma of the Rectum."

"Coccygodynia: A New Method of Treatment by Injections of Alcohol."—By Frank C. Yoemans, A.B., M.D., of New York City, N. Y.

The diagnosis is established by a thorough examination, both general and local. Local examination is made by inserting the index finger into the rectum and palpating the coccyx between it and the thumb outside. The soft parts intervening between the coccyx and anus are now compressed and the point of maximum tenderness is thus located, usually just beyond the tip of the coccyx. Proctoscopy rules out rectitis.

The prognosis hitherto has been better in the traumatic cases than in those of frank neuralgia or neuritis. The writer confidently predicts that the treatment proposed will render the latter equally amenable to treatment.

The writer proposes a treatment based on the suggestion of Schlosser in 1907, of injecting 70 to 80 per cent alcohol in sensory nerves, thereby causing their degeneration as practiced with marked success in trifacial neuralgia.

The technique is simple and can be carried out in the office under strict aseptic precautions. The patient with empty bowel is placed on a table in the Sims' position and the skin about the coccyx painted with tincture of iodine. A 2 c. c. Luer or similar syringe is filled with 80 per cent alcohol and armed with a two-inch needle. The right index finger is now inserted into the rectum and the point of maximum tenderness is determined by counter pressure with the thumb outside. Maintaining the finger in the rectum to guard against puncture and as a guide, the needle is introduced through the mid-line directly to the painful spot, and 10 to 20 minims of solution are injected slowly.

The needle is withdrawn and its puncture sealed with collodion. The pain from the injection lasts a few minutes and is followed by a dull ache which may last a day or two. From three to five injections are usually required at intervals of about one week.

The writer reports seven cases, all women, treated from two months to four years. They required three, four or five injections each at intervals of about one week. Relief was prompt and complete and all the patients have remained well.

"The Technique of the Perineal Operation for Cancer of the Rectum."—By J. A. MacMillan, M.D., of Detroit, Mich.

In every case a preliminary colostomy must be considered imperative. The colostomy provides the only means of discovering whether a radical operation is justifiable or not, supplies physiologic rest for the affected part, and later provides for aseptic conditions in the surgical field.

After thorough divulsion a circular incision is made at the muco-cutaneous line and carried up to the lower surface of the levator ani. Most of the dissection can be done by the fingers. It is not necessary to destroy the external sphincter. This step

of the operation exposes a circular area of the levator ani about an inch and one-half wide. Before proceeding further the hemorrhage should be controlled and the location of affected glands determined.

The next step of the operation includes the division of the levator ani and the removal of lymphatic glands.

The peritoneum may be entered anteriorly and separated laterally, which will leave the mesosigmoid as the only attachment of the bowel. This should be divided as far from its colonic attachment as possible in order to secure the retention of a good vascular supply for the proximal end of the bowel after the excision.

When the gut can be drawn down sufficiently to permit the excision of the affected portion and the attachment of the lower edge of the mucous membrane to the skin, excision is done and the sutures placed. Free drainage is necessary.

The colostomy is not closed until the patient has been up and about for several weeks.

"Myasthenia Gastro-Intestinalis."—By V. Lee Fitzgerald, M.D., of Providence, R. I.

By the term "myasthenia gastro-intestinals" is understood a weakness of the muscles of the abdomen, stomach, intestines, and their supporting ligaments, with a consequent downward displacement of many or all of the viscera.

Many patients suffering from myasthenia in its different forms are in danger of having suspensory or other operations performed upon them, whereas the intestinal stasis can be entirely removed by medical measures and the baneful affects of the underlying ptosis entirely removed.

The general aim in the treatment is the relief of the stasis, and the restoration of the prolapsed viscera to as near their normal position as possible.

The success in the treatment of these patients depends not only upon the relief of stasis, but also upon the patient's active and persistent co-operation.

For the past two years the writer has been treating cases of myasthenia as follows: The patient is given a thorough examination, including that of the gastric contents, urine, and feces. In case of myasthenia of the stomach with dilatation and prolapse the patient is put to bed and fed through a duodenal tube six or seven times a day, depending upon the amount of food needed to nourish the patient. This gives the stomach a complete rest, and it comes up into normal, or nearly normal, position in from ten days to two weeks.

"Further Observations of Pruritus Ani: Its Probable Etiological Factor; Results of Treatment."—(A fourth report, based on results of original research.)—By Dwight H. Murray, M.D., Syracuse, N. Y.

In this report on the fourth year's work of original research on pruritus ani, the author finds there is not much more to give to the profession beyond the confirmation of the work of previous years. He has yet no reason to doubt his claims for the infection theory of pruritus ani.

Twenty new cases have been examined during the past year. In all but two of these streptococcus fecalis has been demonstrated.

It has been found that occasionally the bacterial growth seems to be so lacking in strength that it is difficult to obtain an autogenous vaccine. It is not known why this is so unless it is owing to the very low grade inflammation produced by germs not so active as those found in many other infections.

During this year two cases were treated by other physicians who tried to follow his technique, but in neither case was improvement manifest, notwithstanding that streptococci were found present by the author's bacteriologist, and although the same quality of vaccines were used. With the consent of their physician the author took up the treatment. Improvement was marked. The only point of difference in the technique that he could discover was that the others injected the vaccine deep into the muscle instead of directly into the skin or immediately beneath it.

During the past year the author has had additional proof that the itching does not extend appreciably above the white line of Hilton. He has also had continued confirmation of his previous statement that the moisture found upon the parts is not a discharge from the rectum.

This past year's work again shows that other rectal diseases are not present regularly with pruritus ani, and the belief is confirmed that they are coincidental instead of etiological.

No unfavorable sequelae arose from the vaccine injections. There is now no hesitation in running the dose up to two billion or more dead bacteria. One injection resulted in formation of a jelly-like material in the tissue but this was absorbed. Some time ago a similar swelling was opened and found to be sterile, and no trouble has resulted.

"A Report of Cases of Pruritus Ani Treated with Carnotite."—By Samuel T. Earle, M.D., of Baltimore, Md.

Carnotite, a radio-active mineral, was used in the treatment of eight cases of pruritus ani and was found to be a very satisfactory palliative remedy.

"Treatment of Amebic Dysentery by Emetine Hydrochlorine."—By Alfred J. Zobel, M.D., of San Francisco, Cal.

The writer gives a brief culling from the literature on the emetine treatment of amebic dysentery, and also a few words relative to the drug itself.

He states that in emetine hydrochloride we have a reliable, non-toxic drug possessing a definite specific action which may be administered hypodermically, and yet which will permit of a sufficient dose being given without causing any depression, nausea, vomiting, or local reaction.

He reports two interesting cases in which the disease was present in one individual for ten, and in the other for fourteen years. Under the influence of emetine, within two or three days amebae, blood, mucous, froth, and foul odor disappeared from the dejec-

tions and their number greatly decreased; the racking tenesmus, bearing down feeling in the rectum, the colic, and the abdominal tension, discomfort and gurgling absolutely ceased.

Proctoscopic examinations revealed the favorable influence of the drug upon the amebic ulcerations. No amebecidal irrigations were employed.

He further reports other cases seen by him in consultation which demonstrate most forcibly the necessity for a proctoscopic examination of the bowel and a microscopic examination of the feces in every instance where a diarrhoea lasts longer than a week, even though the patient has never lived in nor visited a locality where the disease is known to exist.

He advises that emetine should be given for at least three or four months at intervals before the patient should be considered free from the possibility of a recurrence, even though he is clinically cured and the amebae can not be longer found in the stools.

"Amebic Dystentery and Its Treatment."—By Dr. Wm. M. Beach, of Pittsburg, Pa.

The writer of this paper states that:

(1) Amebic dysentery in the early stages may be cured with emetine. (2) In cases somewhat advanced emetine is efficacious and at least clinically curative. (3) The use of the duodenal tube, through which to introduce solutions of emetine to any portion of the intestinal tract, should receive trial and consideration. (4) For rapid cure, and control, cecostomy or appendicostomy is the best measure in advanced and chronic cases. (5) Direct irrigation from above is superior to rectal injections, in that it is less than painful and more thorough. (6) The appendix should be removed in most cases of amebic dysentery. (7) The so-called specific emetine can be easily applied in weak solutions.

"The Pathologic Sigmoid Colon and Its Surgery."—By L. J. Hirschman, M.D., of Detroit, Mich.

Studies with the fluoroscope and the sigmoidoscope have shown that true prolapse and invagination of the sigmoid colon into the

rectum is not an uncommon condition. The author advocates shortening the mesentery of the sigmoid by attaching the mesentery of the invaginated or prolapsed portion of the root of the mesentery of the descending colon.

In a number of cases of obstruction to normal defacation, this obstruction will be found in women who give a history of a disturbed puerperium. Radiographic studies of these patients who give a history of chronic obstipation accompanied by pain and marked tenderness in the left lower abdominal quadrant and the region of the womb and broad ligaments, more often the left, show the presence of adhesions which angulate, displace or bind down the sigmoid. The cure of this condition involves the relieving of the adhesions and the covering of raw areas with omental, epiploic or mesenteric grafts, or the excision or short-circuiting of the sigmoid. Another class of adhesions of the sigmoid seriously obstructing defecation is caused by adhesions to the abdominal wound following laparotomy.

Hypertrophy or redundancy of the sigmoid colon is another pathological condition which has not infrequently been met with. When the walls of the bowel contain a large proportion of unyielding fibrous tissue, short-circuiting is insufficient and excision is indicated.

In malignant growths of the sigmoid colon, excision with immediate anastomosis is the ideal indication.

When inoperable it is is the author's practice to always make the colostomy in the median line. This is done for the following reasons: First, the median incision is the best for exploratory purposes. Second, one has the choice of any part of the colon in the making of the colostomy. Third, one gets just as good adhesion and union, with no more liability to hernia, as in the side. Fourth, the patient is better able to cleanse and dress the colostomy in the median line. Fifth, it takes the colostomy opening away from the neighborhood of the iliac crests, and allows of the better fitting of retention apparatus and colostomy shields. Sixth, control of a median colostomy is just as satisfactory as the lateral.

The author has found no difficulty in securing colostomy control by using a small rubber catheter in the mesenteric opening beneath the spur and encircling the upper limb of the colostomy with this catheter, drawing it just snug enough that the mucous surfaces appose. The catheter is held in this position by a seraphine snap and is released by the patient when he wishes to defcate or expel flatus.

"Myxorrhea Coli—Myxorrhea Membranacea and M. Colica (Membranous Enteritis-Mucous Colic)"—By Dr. S. G. Grant, of New York City, N. Y.

The essayist explained that myxorrhea coli was a symptom complex characterized by constipation, abdominal pain, uneasiness or soreness and the periodic evacuation of jelly-like strips or casts of tenacious mucous on the one hand or colic on the other and suggested that all mucous discharges be designated as *myxorrhea coli* with which understanding the former is called *myxorrhea membranacea* and the latter *m. colica.*

The writer conceded that either type of myxorrhea coli may be secondary to neurogenic disturbances but strongly maintained that M. membranacea and M. colica are frequently produced by many other conditions and diseases, medical and surgical, several of which may be factors in the same case. He had often known these conditions to be caused by psychic, neurogenic, gastrogenic and enterogenic disturbances, adenoidism, thyroid disease, impaired metabolism, abnormal menstruation, affections of the heart, liver and pancreas, inflammatory and ulcerative lesions (colitis), helminths, foreign bodies, prolonged or irritating colonoclysis, various lesions which induce chronic intestinal obstruction and led to coprostasis and autointoxication and other ailments which cause the hypersecretion or retention of mucus. The writer had observed patients who suffered at first from myxorrhea membranacea and later M. colica where the mucus became inspissated irritating and excited enterospasm.

The writer maintained that the *diagnosis* was easy in uncomplicated cases and that myxorrhea membranacea could be

recognized by its *symptom complex,* obstinate constipation, uneasiness and soreness or pain in the lower left abdominal quadrant and the periodic discharge of strips, casts, or jelly-like masses of mucus, and that where subsequent to these manifestations and in the absence of signs pointing to intestinal obstructions from other causes colic suddenly supervenes, one is justified in making a diagnosis of myxorrhea colica.

The essayist discountenanced a routine treatment in these cases and advised holding curative measures in the abeyance until the acute symptoms subsided.

The removal or correction of kinks, twists, strictures, invaginations, adhesions, pericolic membranes and other lesions obstructing the bowel or causing stasis, effected a cure in many of the writer's cases and he rarely found the bowel sufficiently incapacitated to require resection, exclusion, or the establishment of an artificial anus.

In conclusion, the writer stated that myxorrhea membranacea and m. colica were common affections and more frequently responded to surgical treatment than the literature of the subject would indicate.

"Peri-Rectal Gumma: Report of two Cases."—By Alois B. Graham, M.D., of Indianapolis, Ind.

The subject peri-rectal gumma owes a great deal of its interest to its rarity. The author reports two cases which are rather unique. They were seen within twenty-four hours of each other, and both presented a typical peri rectal gumma, in that no lesion of any kind could be detected in the rectum of either patient.

The author's conclusions are that peri-rectal gummata are rare. The two cases reported are unique and of interest in that both were typical examples of peri-rectal gummata. In both cases the gumma was seen in its early or vascular phase. In one case it appeared 23 years after the initial lesion; in the other case it appeared three years following the syphilitic infection. Both gummata were painless to palpation and fluctuation was detected in both. An error of diagnosis in one case was responsible for the

incision and subsequent suppuration which followed. In the other case no incision was made and suppuration did not occur. No demonstrable rectal lesion could be discovered in either case. The induration in both cases disappeared rapidly under anti-syphilitic medication. No fistula resulted in either case.

"Anal and Rectal Growths of Benign or Doubtful Character."—By Dr. T. Chittenden Hill, of Boston, Mass.

Hill states that in a series of 3000 rectal cases previously reported there were 49 benign and 76 malignant growths of the rectum. The large majority of these tumors were characteristic and the differential diagnosis was easily made. A few malignant growths seen in an early stage, and some unusual benign types associated with ulceration, were of such a nature that the exact diagnosis was not easily determined.

The writer emphasized the fact that the operative measures to be employed differ radically in each of these conditions. An excision of the rectum is necessary for the malignant cases, a simple local excision is all that is required for the benign growths, where an incision and drainage will suffice for the abscesses and fistulae. Therefore, a doubtful case can not be treated as a breast case in which a complete amputation for a benign growth may be justified. In the case of the rectum there is not alone mutilation, but a high mortality and a serious impairment of function as well to be considered. Furthermore, the removal of a specimen of a suspected tumor is not now approved and this complicates the problem still more.

The histories of several cases which illustrate the doubtful nature of some border line conditions occasionally found in the rectum are cited. They tend to show that aside from benign growth, some of which have many of the characteristics of malignancy, there are certain abscesses which develop in the loose cellular tissue of the retrorectal and pelvi-rectal spaces which are even more suspicious. These indurated, irregular swellings bulging into the rectal ampullae at first resemble very closely the sensation imparted to the finger in malignancy. A little later they be-

come soft and fluctuation is perceptible when all doubt as to their nature is removed. The sinus from an old fistula occupying these same spaces is apt to be much more perplexing than an abscess. As the slow process goes on the rectal wall is crowded into the lumen of the bowel and assumes an irregular, indurated outline which is very suggestive of cancer. Other conditions of similar doubtful character, such as gummatous growths and tubercular ulceration are also discussed.

"Retrorectal Infections."—By Collier F. Martin, M.D., of Philadelphia, Pa.

Martin reviews the histories of sixty-seven cases. In addition to the infection of the retrorectal space many of the cases also had involved the pelvirectal and ischiorectal spaces. Some of the more chronic cases were complicated with stricture of the rectum and multiple fistulae.

Eighty-five per cent of the infections occurred in males. External traumatism was not a factor in this series of cases. The author holds that most of these infections originate from internal traumatism, associated with some condition which lowers the resistance of the individual to pyogenic infection.

Pulmonary tuberculosis appears to be most constant factor in thus lowering the resistance. Twenty-one per cent died from tuberculosis at varying periods, either after examination or operation.

Forty-three per cent of the cases are noted as having pulmonary tuberculosis more or less advanced.

Of the fifty-five cases operated upon, thirty-three were cured. These present sixty per cent of the operative cases, or nearly 50 per cent of the total number examined.

In nearly half of the cases the original abscesses had opened posteriorly, either between the sphincters or at the anorectal line. Pain was not a prominent symptom.

The methods of incision applicable to the various complicating conditions are briefly outlined.

The author lays great stress upon the seriousness of these infections, and upon the necessity of the prolonged watchful after-treatment.

While the prognosis as to both complete recovery of the local condition and the general health, as well as to the preservation of the sphincter control, should be guarded, careful after-treatment and prolonged observation will result in saving a large proportion of these really serious cases.

An abbreviated history of the findings in the entire sixty-seven cases is given.

"Hemorrhoids; Their Treatment."—By Dr. J. Rawson Pennington, of Chicago, Ill.

Dr. Pennington states that clinically hemorrhoids should be classified:

(1) According to their location.

(2) According to their structure.

According to their structure they are divided into (a) those containing fluid blood, (b) those containing clotted blood, (c) those containing both fluid and clotted blood, and (d) those consisting of "skin tabs" or folds of skin.

Most hemorrhoidal cases can be operated on under some form of local anesthesia. He operates on 90 per cent of his cases by blocking the field of operation. The cocaine is usually employed in the strength of from ¼ to ½ of 1 per cent. The quinine and urea in from ¼ of 1 to 1 per cent solution. Sometimes he combines the solutions, the cocaine being used for its immediate effect and the quinine and urea for prolonging the anesthesia.

During the past twenty years he has given a fair trial to a number of methods advocated which promised a reasonably good result, including the ligature, the clamp and cautery, Whitehead, injection, suturing and other methods which unite tissue in mass, and has come very definitely to the conclusion that by far the best way of treating this condition is by the excision or enucleation method.

The operative procedure should have for its object the removal of the cause of the tumefaction. The treatment for each type of hemorrhoid should be practically the same. This should consist in removing an ellipse from the tumor-like formation and in the case of the thrombotic pile turning out the clot, and in that of the internal variety the varicosity and allowing the blood to escape, and in the fleshy pile of dissecting out the excess of tissue.

"Hyperplastic Tuberculosis of the Colon."—By J. M. Frankenburger, M.D., of Kansas City, Mo.

The writer declared that this form of tuberculosis of the intestine differs from other forms of intestinal tuberculosis, inasmuch as it is amenable to operative interference. It is generally a local and primary lesion and is characterized by the formation of tumor masses composed of fibrous and tuberculous granulation tissue in the walls of the bowel. Primarily there is no involvement of the mucous membrane, but on account of the narrowing of the gut the irritation caused by the passage of feces may produce ulceration.

Symptoms are slight, constipation and diarrhoea sometimes alternating. Later the symptoms are those of gradually increasing intestinal obstruction. Differential diagnosis is between sarcoma, carcinoma, syphilis, and chronic appendicitis, with adhesions.

Treatment is purely surgical. If possible the entire growth should be removed, but failing in this a short circuiting operation should be performed to relieve the obstruction.

Two cases are reported with successful operations.

"Pseudo-Intestinal Stasis and Real Intestinal Stasis, Demonstrated Roentgenologically."—By Arthur F. Holding, M.D., of New York City, N. Y.

Attention is called to many anomalies of visceral position and progress of the bismuth meal that have been interpreted as pathologic, and which are really physiologic or anatomic anomalies

and completely compatible with health, laying especially stress upon the fact that the ileum enters the caecum normally at an angle, and unless associated with proximal distension, a diagnosis of Lane's kink is not justified.

He emphasized the point that delayed progress of the bismuth meal is not significant of obstruction unless it is more than six hours behind the normal schedule and associated with marked distension of the viscus proximal to the locus of obstruction. Proximal distension with obstruction to the bismuth column are the two cardinal diagnostic points of real intestinal stasis. Intestinal obstruction, due to tumors, is much easier to diagnose than intestinal stasis, because the defect in the bismuth shadow made by the tumor is more definite than that made by adhesions, veils, or membranes.

"Local Treatment of Anal Fissure."—By James A. Duncan, M. D., of Toledo, Ohio.

The writer describes a treatment for anal fissure which he has employed successfully for the past thirteen years. The fissure is brought into view by separating the folds, and the surface is lightly curretted, then thoroughly dried, and a drop of collodion applied. This takes only a moment or so. A recent ulceration requires but a single application. A sharp, stinging pain, lasting for only a few minutes is caused, and then the patient is left perfectly comfortable.

"Some Unusual Phases of Sigmoidoscopy."—By Ralph W. Jackson, M.D., of Fall River, Mass.

The diagnostic value of the sigmoidoscope has been the topic of much writing, and is increasingly appreciated by hospitals, but much less so by the profession and insufficiently in medical teaching. Explicit statements of its considerable therapeutic uses are not found in German, American or English literature. The instrument enhances the extent and accuracy of recto-sigmoidal therapeutics, and specifically it facilitates the use of certain other instruments, topical applications, the relief of high impaction, and

the treatment of stricture and many other lesions. Serious trauma from the sigmoidoscope is more liable to happen than some authorities admit, as illustrated by three cases of intestinal perforation cited from the German. Two personal cases are detailed, where the patients were in serious condition from occlusion of the bowel, but were relieved and saved by sigmoidoscopy done with diagnostic intent only. Pelvic visceroptosis, hypermobility of the sigmoid, and the fixed and open rectal ampulla beneath predispose to invaginations and angulations which are fairly frequent in mild and chronic form, and are potentially dangerous as a source of acute obstruction. Sigmoidoscopy, properly conducted, empties the pelvis by gravity (due to the position assumed by intelligent introduction of the instrument and by the air pressure admitted through it, and therefore tends to undo such intestinal malpositions. The occlusion in the two cases related was unexpectedly relieved, and doubtless in this way. Greater prevalence in the use of the sigmoidoscope would bring to light a field for deliberate therapeutic use of the instrument along these lines.

"Crude and Careless Diagnostic Methods, and Results of Same, in Some Recto-Colonic Conditions."—By John L. Jelks, M. D., of Memphis, Tenn.

The author criticises the busy doctor and surgeon who too hastily yields to a conclusion and treats recto-colonic diseases without sufficient investigation to warrant or obtain a correct diagnosis.

Reference is made to cases operated on for appendicitis, which disease may be an extension of an infection and inflammation originating in the rectum or colon.

Cases are cited to show the frequency and at all times the liability of mistaking a condition for an infection or ulceration of the colon, specific in character, when a coloptosis or pericolic membranes, or both, were the true etiologic factors. Stress is laid on the importance of urinalysis, microscopic examination and the X-ray in recto-colonic cases.

A harder nodular calcareous degeneration of the outer zone of the mamma has been observed as a sequence of coloptosis and defective drainage. In another case, in which was found a cecum cradled in pericolic membranes, and a coloptosis, a duodenal ulcer was diagnosticated. In this case the urinalysis, the history, and general toxic appearance of the patient, pointed to true etiology.

Case reports are given in which diarrhea was the dominant symptom, though impactions, pericolic membranes, and ptosis were the true etiology.

The author calls attention to his prior reference to, and work of establishing the importance of conserving the ilio-cecal valve; also to the syphonage of a ptosed colon after short circuiting operations, which he accomplished by a second anastomosis between the blind colon and the sigmoid or rectum below the first anastomosis.

Importance is claimed for a microscopic examination of the intestinal contents of patients who suffer from attacks of appendicitis, and of the contents of the removed appendix; and the author insists that in the event that pathogenic amebae are found appendico-cecostomy should be performed instead of appendectomy.

The author refers to his observation of quite marked congestion of blood in the visceral vessels themselves in these cases of ptosis and defective intestinal drainage.

The author refers to the frequency with which he encounters cases of inoperable cancers of the rectum and intestines, the neglect of which is most often due to the fear of examination of those suffering with symptoms in the region referred to.

Reference is made to the operation of appendico-cecostomy as being practically free of danger to life. In his opinion this operation would save almost every life that is today caused by the ravages of amebic colitis.

"Abscess Originating in a Pilo-Nidal Sinus."—By Louis J. Krouse, M.D., of Cincinnati, Ohio.

The writer states that a pilo-nidal sinus is a congenital defect due to a faulty development of the foetus. It is usually located in the median line over the coccyx or the sacrum. Inflammation developing in the sinus is followed by burrowing of pus into the neighboring tissue. Inflammation of this sinus must be differentiated from necrosis affecting the sacral or coccygeal bone; from abscess originating in the sebaceous gland of this region; and from true fistula-in-ano. The treatment consists in the complete obliteration of the walls of the sinus.

"Abnormalities of the Colon, as Seen with the Roentgen Ray: Lantern Slide Demonstration."—By W. I. LeFevre, M.D., of Cleveland, Ohio.

The entire alimentary tract can now be successfully examined with the X-ray, some parts more readily and successfully than others, according to the degree of satisfaction arranging themselves in the following order: Colon, stomach, oesophagus, small intestine. Two methods of examination are used. First, Roentgenoscopy, which is the examination with the fluoroscope. Second, Roentgenography, the making of X-ray plates. The colon is also accessible from either end, that is, it can be examined by following the bismuth meal through from the stomach, or by giving an opaque enema of barium sulphate. In the former method the motor phenomena of the colon can be observed, in the latter the size, position and contour can be seen.

The action of atropin, adrenalin, pilocarpin and physostigmine as affecting the action of the bowel is briefly discussed.

The normal colon is described in detail, with radiographs showing different types. Many vary from the "ideal" type and still are normal for that individual.

Abnormalities of the colon may be produced by congenital defects, disease or injury to the bowel proper, from pressure, constriction or relaxation of other organs in close proximity. Colop-

tosis, owing to its frequency and importance is first discussed with radiographs showing these conditions. Other abnormalties consist of stenosis, malignant growths, tuberculosis, kinks, twisting ,hernias, diverticulae, and megacolon or Hirschprung's disease. All these conditions can be recognized by aid of the X-ray.

"Some Problems Before the American Proctologic Society."—By J. A. MacMillan, of Detroit, Mich.

The writer states that—(1) during the past decade proctology has come to include diseases of the colon, and that the extension is beneficial inasmuch as it encourages and provides for a better diagnosis, and for a more thorough search after etiology. (2) The effort should be made by the American Proctologic Society to standardize some of well tried methods of treatment which have been proven effective and reliable. That on the other hand there are certain procedures in common use that are faulty and pernicious, and that it should be the aim of the Society to begin a campaign of education against these. (3) That in regard to rectal cancer he recommends that statistics from the members of the society be collected annually, and utilized to ascertain the prevalence, and location of the disease, together with the extent of surgical interference or noninterference, kind of operation, and subsequent results.

The writer recommends that a cancer committee be appointed to take charge of this work.

Extracts from Home and Foreign Journals.

SURGICAL

Radium in Cancer.

The papers on radium therapy in this and recent numbers of The Journal, in addition to being instructive in themselves, are indicative of the interest in the subject at the present time. Radium therapy is going through the period of enthusiasm that Roentgen-ray therapy experienced ten years ago. This is perhaps inevitable, and after it the method will doubtless settle into its true place in therapeutics. It is not a new discovery that radium has interesting and useful possibilities. That was shown by Wickham and others several years ago. Indeed, we know enough from our experience now to predict with considerable assurance the extent of these possibilities. Radium is useful in numerous dermatoses; and, passing to the larger subject of cancer, it is indisputable that radium can be used successfully to destroy certain localized malignant growths, that is, growths on the surface whose entire extent can be sufficiently exposed to its energy. Extensive growths involving deep structures and disseminated growths are beyond its control, and there is no reason to believe that they will ever be brought within its control, for all experience with radium and the Roentgen rays has shown that these agents are useful in malignant growths only so far as they destroy the cancerous tissue. In fact, there is every reason to believe that the extent and the limitations of therapeutic usefulness of the two agents are essentially the same, as are, indeed, the actinic energies of each. We have, then, a considerable experience on which to base our estimate of the usefulness of radium therapy, and from this experience there is no justification for the promise of relief in extensive cancer from the use of radium, or for the hope that with large quantities of radium we would be

much nearer the solution of the problem of the cure of cancer in general than we are now. Radium has a useful therapeutic field, and it would be unfortunate for its therapeutic reputation to be damaged by exaggeration or injudicious enthusiasm.—*The Jour. of the American Med. Asso.*

Present Status of Joint Diseases and Best Method of Treatment.

Diseases of a joint is due in all cases to a secondary infection which reaches it through the blood, except in those cases due to direct injury of the joint. The infection is pyemic, tuberculous, or syphilitic. In the chronic polyarticular cases of arthritis the etiology has not yet been fully established.

The stereoscopic radiograph is a very valuable aid in establishing a differential diagnosis.

Cold abscesses should not be opened and drained with a tube, as secondary infection follows and produces serious, if not fatal, results. They should be aspirated with a trocar and then injected with some such substance as bismuth paste. If secondary infection should occur in spite of this treatment, Beck advises the use of his bismuth paste which he believes will cure at least 50 per cent of these apparently hopeless cases.

The Rollier heliotherapy will also cure a large percentage of tuberculosis bone and join lesions, even in the presence of open sinuses.

Likewise massive doses of the X-rays have been effective of cure in the hands of Baish, Iselin, Schede and others.

Garre has reported a collection of over a thousand cases of tuberculosis treated surgically in various European climes, and shows that operative procedures give a very high mortality compared with conservative methods of treatment.—*Pediatrics.*

Osteoarthritis of the Hip.

R. L. J. Llewellyn and A. B. Jones are convinced that careful physical examination supplemented by a discriminating analysis of the subjective symptoms will enable one to diagnose the oncoming of an osteoarthritis even prior to the formation of bony outgrowths. The early symptoms consist of pain (local and referred), tenderness of hip, alterations in attitude and gait, with limitation of mobility. Like tuberculosis coxitis the pains of osteoarthritis in this joint may either be localized to the hip region or referred along one or all of the nerve trunks from which the articulation derives branches. Quite in the initial stages a feeling of pain, or rather of painful stiffness, is felt in the joint itself. Sensitiveness to palpation of the capsule of the hip is a very common sign, but needs careful examination for its detection. Referred pains at their onset are more often than not dismissed as examples of pure sciatic or crural neuralgia, and regarded as of gouty and rheumatic nature the unhappy victim for years roams from spa to spa in search of relief. The chief peculiarity of these pains is not so much their intensity as the extraordinary length of the period they endure. Thus patients with well-marked malum coaxe always assert that they have not only for years, but for two or even three decades suffered with these pains. Almost invariably these subjects suffer at the same time with pain in the loins, which, of course, enhances the liability to confusion with scatica —a condition so commonly associated with lumbago. In the initial stages no change in gait and attitude can be detected save in the temporary limping that follows the occasional incarceration of the enlarged synovial villi. But with their growth and the advancing involvement of the membrane the intra-articular irritation produced gives rise to spasm of the related muscle, and this is malposition through slight flexion of the hip-joint. Relative fixity of the joint is, of course, the sign of chief diagnostic importance, and even in the very earliest stages there is present some limitation in the arc of motion in the hip. The presence of flexion contracture is of prime value as an indication of the articu-

lar site of the affection, but there are always present also further restrictions of movement. The diagnosis of osteoarthritis of the hip in its terminal stages presents no difficulty, but unfortunately at this period in its life history treatment is of little avail.—*Medical Record.*

MEDICAL

The Value of Skimmed Milk and Its Dilutions in Fever.

L. Fischer believes that in pneumonia one should give no more than one-half of the quantity of milk formerly given. The frequency of feeding should also be reduced. Solid food should be prohibited during an acute febrile attack, regardless of the diagnosis, so that eggs, meat, vegetables, and bread should be prohibited. On the other hand gruels may be permitted in many diseases. Thus a farina or oatmeal gruel, or a barley gruel made with diluted milk is well borne and may be ordered. Fruit juices, such as orange juice and pineapple juice, are grateful and quench thirst. One of the best remedies to give is water for its antipyretic and laxative effects, and because it stimulates the kidneys. The tolerance for carbohydrates during fever is limited and in many cases they are contraindicated. Fat in the form of butter or cream is also contraindicated. Skimmed milk should be diluted with an equal quantity of water. By this method of feeding there is given a very low percentage of sugar and casein and practically no fat.—*Medical Record.*

Kubisagra of Gerlier's Disease.

L. P. Couchoud, Rev. de Med., April, 1914. This occurs only on the Franco-Swiss frontier and in the north of Japan. It was described independently by Gerlier and Nakano in 1844. It is a summer disease, occurring paroxysmally, usually while the patient is at work. There is weakness of the hands and arms, severe

pain in the cervical region, the head falls forward and the eyelids droop. The gait is reeling and the patient may fall. There may be transitory failure of vision or diplopia. The cat is subject to the disease, and Couchoud has used it in experimental work. He claims to have demonstrated a staphylococcus, gram-negative, not liquifying gelatin, feebly agglutinated by the serum of patients and inducing the disease in cats, though not pathogenic to mice or frogs. He terms it the Micrococcus paralyticans. The prognosis of the disease is good, attacks ceasing with the advent of cool weather. (Note: Similar symptoms occur commonly from overwork, mild isolation, especially in poorly nourished subjects with mild sepsis from cuts and scratches or intestinal saprophytosis. Staphylococci can be "isolated" from almost everyone. Unless the bacteriologic identification is absolute, we are sceptic as to the regional limitation of a specific disease to two widely different localities, from which emigration has occurred extensively.—*Buffalo Med. Journal.*

Quinin Treatment of Rabies.

The quinin treatment was tested by Summing against fixed virus, as well as, against street virus. The former was a six-day virus, while the latter killed rabbits in about ten days, and guinea-pigs in eight days. The virus was given intracranially; the bisulphate of quinin was used in all experiments, the injections being intraperitoneal. The results were negative. The experiments were controlled both as to the infectivity of the virus and as to the absence, for the most part, of untoward symptoms from the quinin treatment. The dose of virus in most of the tests was not much larger than the smallest infecting dose. This amount of the virus is approximately 1-200,000 part of the total virus in the brain and spinal cord of a rabbit at the beginning of the paralytic stage. Inasmuch as the quinin failed as a preventive measure against extremely small doses of virus in actual tests, Cumming asks whether it can not reasonably be assumed that this method of treatment is of no curative value in cases of hydrophobia mani-

festing symptoms in which the amount of virus would be many thousand times greater? In the absence of protection by quinin against small doses of virus, even when a series of daily injection of rabic virus, Cumming says, we can not expect favorable results from quinin after symptoms of hydrophobia have developed.—*The Journal of the American Medical Association.*

Graft of Monkey's Thyroid Improves Myxedema.

Voronoff's patient was a boy of 14 who had developed myxedema after measles at the age of 8. The graft of the right lobe of the thyroid with its parathyroids was taken from a large monkey—a baboon—and implanted in the neck of the boy. It was embedded in a vascular region and was sutured to the surrounding tissue in order to promote adhesions and formation of new vessels. Voronoff states that during the six months since, the gradual improvement in both the physical and mental condition has been striking. The boy had formerly been apathetic and stupid, the skin scaling off, the nose and lips enlarged; all this has retrogressed and the features show nothing abnormal while from his former apathy in school the boy has become lively and unruly.—*The Jour. of the Amer. Med. Asso.*

On the Effect of Scarlet Red in the Treatment of Gastric and Duodenal Ulcer.

Fridenwald and Leitz (Monthly Cyclopedia) note that Davis has suggested the use of scarlet red in the treatment of ulcer of the stomach, having proved its usefulness experimentally in animals. The powder is reddish-brown in color, giving scarlet red in oil solutions. It is tasteless, neutral to litmus, in 1 per cent oil solution, insoluble in water and urine, even after boiling. It is soluble in alcohol, ether and chloroform, olive oil, fats, fatty oils, turpentine, warmed petrolatum, and paraffin. One gramme of

finely divided powder, heated gradually in 100 c.c. of olive oil to 200, remained in solution for two days or more at ordinary room temperature. Approximately a 2 per cent solution can be made, but the scarlet red does not stay in solution for any length of time, and tends to precipitate at once on cooling. Gastric juice, experimentally ,has no effect on the scarlet red. Agar and bouillon cultures give abundant growths with staphylococcus and colon bacillus, despite the addition of 1 per cent solution of scarlet red. When given by the mouth it is a fat-selecting vital stain. In the course of months the stain is gradually eliminated. Subcutaneous and intraperitoneal injections stain only the fat in actual contact with the scarlet red solution.

Scarlet red may be administered in doses of 15 to 20 grains three or four times daily without the slightest toxic effect, provided a pure preparation be employed. It is best given in 7½-grain konseals, two of which may be taken three or four times daily before meals. It may, however, be administered in much larger doses and only after very large continuous doses can the odor of camphor be detected in the urine. There was not the faintest toxic symptom during its employment in over 100 patients. Of thirty-seven cases treated by the scarlet red, these being instances in which the result of the rest cure was unsatisfactory, or ambulatory cases which remained unbenefitted by the treatment, the great majority were cured. The dosage per diem varied from 40 to 50 grains. While at is held that the drug can not replace the usual forms of treatment, it is urged that when it is administered in conjunction with them it frequently renders the cure more effective. Its use need not interfere in any way with the administration of other remedies, such as the alkalies or belladonna, when indicated, and, in fact, the effect of the combination is at times most beneficial.—*The Therapeutic Gazette.*

Enuresis—Nocturnal.

Dr. John Ruhrah, in the Amer. Jour. Med. Sciences, says: Among the more interesting of newer suggestions as to treatment

are the results of Williams in treating these cases by the use of desiccated thyroid. His cases had subnormal temperature and evidence of thyroid insufficiency, and he obtained wonderfully satisfactory results in all except one case, and in this case the child did not have a subnormal temperature. Williams gave one-half grain of the dried thyroid twice daily to children between two and six years of age and this may be increased for older children. The increase in dosage should be made slowly as directly opposite effects are occasionally induced by overdose. Ruhrah has used this method and in a small proportion of cases in which there were more or less marked signs of thyroid insufficiency, the results were quite remarkable. These were children with adenoids and enlarged tonsils, or in some cases, children in whom the adenoids or tonsils had been recently removed. In his cases the effect was obtained promptly or not at all. In every case in which a favorable result was obtained, a marked difference was noticed after the administration of one or two doses of the drug, and in all cases within a week. Another remarkable observation coinciding with that of Williams' is that the undersized children gained weight rapidly. When there is no other indication for treatment he has found the use of atropin to give better results in a great number of cases than any other one thing, and to be of any service it must be given in full doses. In nocturnal cases a dose at five o'clock and at bedtime is all that is required. In cases occurring both during the day and night the drug is advised every three hours. He usually prescribed one grain of atropin sulphate in two ounces of water, each drop containing about 1-1000 grain, and usually as many drops will be required as the child is years old. The proper method of dosage, however, is to start with one or two drops, increasing each dose one drop at a time until flushing of the face and neck occurs some twenty minutes after taking the drug. The dose should then be diminished one drop, and this amount continued until the child has ceased urinating at night and for at least two weeks later, when the drug may be dropped gradually, diminishing a drop at a time until one drop is reached when it may be stopped.—*Pediatrics.*

Hemorrhage from Throat in a Bleeder.

A woman was brought to me yesterday, from Corbin, Ky., with the statement that, about a week ago, she had had what was thought to be quinsy, which had ruptured, accompanied by considerable hemorrhage, and ever since that time she had been having profuse hemorrhages from the throt. I was told that she had been losing from a pint to a quart of blood every day for a week, and she was beginning to show the effects of it. When she was brought to my office I examined her, and found that on the left side she had quite a large tonsil, and just in front of the tonsil, on the anterior pillar, there was an opening from which blood was oozing. I cocainized the throat, introduced a pair of forceps and pulled out a strip of one-inch gauze nearly two feet in length, which had been packed in there by her physician to stop the flow of blood. I cleaned out the clots and then she began to bleed, and this hemorrhage continued in spite of everything I could do. I cauterized it, applied adrenalin gauze and peroxide of hydrogen gauze, and today I gave her 10 c.c. of horse serum. Yesterday I put her on calcium chloride. She has a baby about ten weeks old which is nursing. Evidently she is a bleeder. No blood examination has been made. The opening is in the anterior pillar nearly opposite the supra-trianular fossa.

P. S.—The serum had a magic effect, the hemorrhage ceased and she had no more bleeding.—*The Louisville Monthly Journal of Medicine and Surgery.*

Typhoid Vaccine Therapy.

In a study of the vaccine therapy of typhoid fever Albert A. Hornor, of Boston (Boston Med. and Sur. Jour.), in one hundred and thirty-five cases, comparing forty cases where vaccines were administered with ninety-five cases where vaccines were not used, gives some very suggestive figures. The one hundred and thirty-

five cases were treated alike save for the use of vaccines. The average duration of fever in uncomplicated cases not receiving vaccines was 23.08 days. The percentage of cases showing complications were: inoculated, 55; uninoculated, 50½; all cases, 51. The percentages of mortality were: of vaccinated cases, 10; of unvaccinated cases, 11½; of all cases, 11 1-10.

The duration of fever in uncomplicated cases was approximately the same where the cases did or did not receive vaccines. Defervescence in the uncomplicated cases began usually on the third day after admission, no matter whether vaccines were or were not administered. A more detailed study of the incidence and of the character of complications shows relapses occurring in 20 per cent of inoculated cases in contrast to 11.5 per cent of uninoculated cases; recrudescence in 17.5 per cent of inoculated cases as against 28.4 per cent of uninoculated cases; other complications in 37.5 per cent of inoculated cases compared with 21 per cent of uninoculated cases. In brief, the incidence of recrudescence was much less in the vaccinated than in the unvaccinated cases, while relapses and other complications were much more frequent in those vaccinated than in those unvaccinated. The latter class of complications includes hemorrhage, perforation, phlebitis, pneumonia, parotitis, tonsillitis, osteomyelitis, acute hallucinosis, Vincent's angina, and decubitus.

Analyzing the causes of the four deaths occurrng among cases treated with vaccines, we find the first death due to an intestinal perforation, after the fifth inoculation of vaccine and after patient had received a total of 150 million dead bacilli; the second death was due to septic parotitis developing during a relapse which began after three weeks without fever and after patient had received 880 million killed bacteria; the third death was due to an intestinal hemorrhage occurring on eighteenth day after patient's admission to the hospital and after he had received 530 million dead organisms; the fourth death was due to bronchopneumonia on patient's twenty-first day in hospital and after he had received 580 million killed typhoid bacilli. These deaths were obviously not due to complications extraneous to typhoid fever.

The deaths occurring among 95 cases not inoculated with dead typhoid bacilli were as follows: 4 pneumonia, 2 hemorrhage, 3 severity of the disease, 1 perforation, 1 alcoholism.—*The Lancet-Clinic.*

OBSTETRICAL

Treatment of Eclampsia on Basis of Retention of Salt.

Christiani insists on the importance of the retention of salt as an element for the prognosis in eclampsia. In a case reported this, in connection with the other symptoms, compelled immediate cesarean section, saving both mother and child in an extremely severe case of eclampsia. Notwithstanding venesection and infusion the amount of urine fell off to 135 c.c.; the albumin had increased from traces to 12 per thousand, while there was only 0.4 c.c. of salt to the liter. The morning after the operation the albumin had dropped to 2 per thousand while the salt had risen to 2 c.c. per liter. In some other typical cases cited the severe symptoms appeared and disappeared parallel to the drop and rise of the salt curve in the urine. His experience has been that retention of salt occurs with the uncontrollable vomiting of pregnancy and even before there are signs of albuminuria. Its importance as a guide to treatment in this case is obvious.—*The Journal of the American Medical Association.*

Anesthesia of the Uterus.

Kraus implies that local anesthesia is but a stepmother to the uterus. The first attempts were directed to the cervix and parametria, while Sellheim obtained superior results with conduction anesthesia. The author believes he has hade a further advance by employing pressure anesthesia, so well known to the dentists. The stretching of the cervix is a painful operation. The operator inserts into the cervix rods of cocoa butter, which contain the proper content of novocain—suprarenin. These can be pressed

quite up to the fundus, after which they melt and the entire mucosa is rendered anesthetic. Hegar's dilator is then introduced. To improve the asepsis the latter was coated with melted cocoa butter containing the anesthetic and the whole, after the butter had hardened, pushed into the cervix. The first results were imperfect and instead of cocoa butter a syrup containing the anesthetics was substituted. The syrup was boiled and allowed to congeal on the dilator. Thus far asepsis and anesthesia have been assured. The author has operated upon 24 cases of endometritis (curettage) with the above anesthesia, with satisfactory results.—*Medical Record.*

Pituitary Extract.

George L. Brodhead, of New York (New York Med. Jour.), in an address before the Medical Association of the Greater City of New York, on the use of the pituitary extract in obstetrics, declares that the extract, when used intelligently, in the absence of disproportion and with good cervical dilatation, is a very valuable and a comparatively safe therapeutic agent. The fetal heart must be carefully watched, and chloroform should be at hand to relieve violent contractions, with the forceps ready for instant use. The extract gives satisfactory results, as a rule, and is well worth a trial in properly selected cases. He has usually given one c. c. as the initial dose, repeating every twenty minutes, if necessary, until three doses have been given. If three injections fail, he discontinues the use of the extract.

In Cæsarean section, he has injected the extract immediately before making the incision, with excellent results. The uterus contracts well and the operation is made easier because of the comparative absence of hemorrhage.

For post partum hemorrhage he has never relied upon the extract alone, always combining it with ergot. He has no reason to doubt, however, that the quick action which is obtained in the use of the extract is of undoubted value in the treatment of this variety of hemorrhage.—*The Lancet-Clinic.*

Successful Treatment of Tetanus Neonatorum.

The undoubted power of magnesium sulphate as used by intraspinous injections over the convulsions of tetanus is offset by the fact that death may still occur from severe complications, which may well be ascribed in part to the paralyzing action of the drug. Attempts are naturally being made to neutralize the overaction of the magnesium. Before the Pedriatic Section of the Verein für innere Medizin und Kinderheilkunde, Berlin, which met last July (*Berliner klinische Wochenschrift*, July 27) Falk reported three cases of tetanus neonatorum, seen within four months, in all of which recovery ensued. The solution of magnesium sulphate employed varied from 8 to 25 per cent. To offset the paralyzing action chlorate of calcium was injected. In discussion Finkelstein added that the duration of the disease was not diminished, but the treatment certainly prevented the violent convulsions which often terminate life suddenly and, morover, gave opportunity to push nourishment while the jaws were relaxed. Falk stated, that feeding must be done early, and that one must be sure that the magnesium has not caused deglutition paralysis. Late feeding might set up spasms.—*Medical Record.*

Artificial Sex Control of Pigeons.

That artificial control of sex has passed the experimental stage was the statement made by Dr. Oscar Riddle, in charge of the evolution station of the Carnegie Institute, in addressing the American Academy of Medicine at Atlantic City. "The station is propagating sexes at will with pigeons and doves," said Riddle. "The sex of frogs and toads is settled by manipulation and that of cattle to some extent can be regulated through fixing the mating period." As to human beings, Dr. Riddle said the extent of sex control would depend upon the success now being attained by scientific experiments with mammals and he would not be surprised if eventual success was achieved.—*The Medical Herald.*

Treatment of Cancer of the Uterus.

From 1896 until December 31, 1913, Wilson operated on 956 cases of uterine cancer. Of these, in 67 the disease affected the uterine body. Among the 67, 15 vaginal hysterectomies with no mortality, and 29 abdominal hysterectomies with 3 deaths, were performed. Until the end of 1913 there were 529 cases of cancer of the cervix uteri. These can be conveniently divided into two groups according as operation by the vaginal or the abdominal route was the method of choice. In the first period, lasting until the end of 1905, there were 246 cases of which 37 were operated on by the vaginal method with one death, and 7 by the abdominal route with 6 deaths. In the second period, from January 1, 1906, to December 31, 1913, 283 cases were seen, among whom 20 were operated on by the vaginal route with no deaths and 72 by the abdominal with 8 deaths. The total immediate mortality of the vaginal method has been 57 cases with one death, or less than 2 per cent; and of the abdominal, 70 operations with 14 deaths or 17.7 per cent. The great majority of abdominal hysterectomies were performed by Wertheim's method. The ratio of operability has steadily increased; and in the years 1896 to 1899 it was 14 per cent; in the last four years it has been more than 14 per cent.

The total five years results up to June 30, 1909, have been investigated and show that, with an increased operable ratio and the adoption of the abdominal method of operation the absolute curability of Wilson's cases have risen from 5.5 to 10.2 per cent. Of the patients surviving operation 16 of 51=31 per cent of the vaginal, and 10 of 23=43 per cent of the abdominal, remained well and free from recurrence for five years and upward.—*The Jour. of the Am. Med. Asso.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

A Federal Department of Health.

We wish to call the attention of our readers to the fact that now is an opportune time for every member of the profession, every county, state, sectional and national society, in fact every unit of force in the profession to get together and fight hard for the creation of the much needed and long desired Department of Public Health. That there will eventually be such a department, few of us doubt but that it will result soon is not assured by any means.

Many of us thought this department would be created during the administration of Roosevelt, and after the bill was defeated under Roosevelt our hopes were strong that Taft and his party would pass the bill. However our most sanguine hopes were destroyed and any hopes we may now entertain are doomed to the same disappointing termination unless every member of the profession uses all his influence, both directly and indirectly, with the Congressmen in his district.

Now that Col. Gorgas has completed the Panama Canal, the most wonderful achievement of medical science of all ages, the time is most opportune to have Congress create this badly needed department and to honor Col. Gorgas by placing him at its head.

That our government has no such department is not only a disgrace to the nation but also a reflection upon Congress. It shows that our Congressmen have not grasped the fact that the health

of a nation is its strongest asset in times of peace as well as in times of war and that such a department would mean a financial saving to the nation of millions of dollars. That the medical profession needs the aid of a Federal Department of Health in its fight against disease is easily appreciated when we consider that competent statisticians estimate that the annual death rate could be cut down by 500,000, that millions of dollars could be saved were such a department created. Monuments to members of our profession are few and far between and yet there are many physicians who are willing to sacrifice their lives to advance the science of medicine and promote the welfare of the human race. Let us hope and strive for a Federal Department of Health as a monument to American science in general and to the great sanatarian, Col. Gorgas, in particular.

"Twilight Sleep."

(When you hear about "Twilight Sleep" think about H.-M-C (Abbott).

Two lay magazines, with a combined circulation of more than two million copies, are conducting one of the most aggressive campaigns of publicity ever undertaken in this country. These periodicals have got hold of the fact that it is possible to make childbirth painless, through the use of scopolamine (hyoscine) and morphine, and they are spreading this knowledge broadcast. Within six months there will not be an intelligent woman in America who doesn't know about this method. When these women learn that it really is possible to escape the terrible pangs of labor, and that you can help them to take advantage of it in their homes, they will be clamoring at your door for the "twilight sleep" when the time approaches for the baby to come.

"What is this wonder-working thing, this Twilight Sleep?" asks the Ladies World; and it answers, "Nothing in the world but the skillful use of anesthetics to produce that very fine balance between the states of consciousness and unconsciousness where the patient can not recollect immediate sensations, such as pain,

yet is in full possession of her muscular power and her will to help. These are the ideal conditions for a safe, normal, painless birth. They have been obtained by the great physicians of Germany. They can be obtained by the equally skillful doctors of America. They can be obtained in your town and mine, in the childless home of that terrified young husband, in your home and your daughter's home—everywhere."

All that can be accomplished with scopolamine and morphine, at Freiburg or elsewhere, can be accomplished—is being accomplished in thousands of cases—with H-M-C (Abbott).

The "Twilight Sleep" is available for you in your town in your practice. In H-M-C (Abbott) are provided the necessary drugs, in proper combination, to meet most obstetrical conditions. The exact method of using it is described in a little booklet, which (with prices (The Abbott Alkaloidal Company, Ravenswood, Chicago, will send on request.

Better order your supply of H-M-C at once. You may have a case requiring its use this very day. Drug prices are soaring, and the price of H-M-C, already advanced under stress of the European war, may be higher at any time.

Examination of Candidates for Assistant Surgeon.

Treasury Department,
United States Public Health Service.
Washington, August 25, 1914.

Boards of commissioned officers will be convened to meet at the Bureau of Public Health Service, 3 B Street, SE., Washington, D. C., and at the Marine Hospitals of Boston, Mass., Stapleton, N. Y., Chicago, Ill., St. Louis, Mo., New Orleans, La., and San Francisco, Cal., on Monday, October 19, 1914 at 10 o'clock a. m., for the purpose of examining candidates for admission to the grade of assistant surgeon in the Public Health Service, when application for examination at these stations are received in the Bureau.

Candidates must be between 23 and 32 years of age, graduates of a reputable medical college, and must furnish testimonials from two responsible persons as to their professional and moral character. Service in hospitals for the insane or experience in the detection of mental diseases will be considered and credit given in the examination. Candidates must have had one year's hospital experience or two year's professional work.

Candidates must be not less than 5 feet, 4 inches, nor more than 6 feet 2 inches ,n height.

The following is the usual order of the examinations: 1, Physical; 2, Oral; 3, Written; 4, Clinical.

In addition to the physical examination, candidates are required to certify that they believe themselves free from any ailment which would disqualify them for service in any climate and that they will serve wherexer assigned to duty.

The examinations are chiefly in writing, and begin with a short autobiography of the candidate. The remainder of the written exercise consists of examination in the various branches of medicine, surgery, and hygiene.

The oral examination includes subjects of preliminary education, history, literature, and natural sciences.

The clinical examination is conducted at a hospital.

The examination usually covers a period of about ten days.

Successful candidates will be numbered according to their attainments on examination, and will be commissioned in the same order. They will receive early appointments.

After four years' service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon.

Assistant surgeons receive $2,000, passed assistant surgeons $2,400, surgeons, $3,000, senior surgeons, $3,500, and assistant surgeon generals, $4,000 a year. When quarters are not provided, commutation at the rate of $30, $40, and $50 a month, according to the grade, is allowed.

All grades receive longevity pay, 10 per cent in addition to the regular salary for every five years up to 40 per cent after twenty years' service.

The tenure of office is permanent. Officers traveling under orders are allowed actual expenses.

For invitation to appear before the board of examiners, address "Surgeon General, Public Health Service, Washington, D. C."

Special Anesthesia Supplement.

Recent years have been marked by some important contributions to the theory and, especially to the practice of surgical anesthesia, but there has lacked what is now quite needed for the further scientific development of this alongside the other departments of surgery—a journalistic medium and editorial mouthpiece.

The American Journal of Surgery will be expanded to meet this need. Beginning with the October issue and quarterly thereafter, this journal will publish a 32-page supplement devoted exclusively to Anesthesia and Analgesia.

This supplement will be a complete journal within a journal containing editorials and communications, abstracts, transactions of Societies and book reviews.

The supplement has been adopted as the official organ of the American Association of Anesthetists and the Scottish Society of Anestheiists and it will also publish the transactions of other like societies.

The editor of this supplement will be Dr. F. Hoeffer McMechan of Cincinnati, one of the founders of the American Association of Anesthetists and a charter member of the New York Society of Anestheists.

He will be assisted by a staff of well known specialists in Anesthesia, among whom we would mention:

Dr. James T. Gwathmey, New York.

Dr. Willis D. Gatch, Indianapolis, Ind.

Dr. William Harper De Ford, Des Moines, Ia.

Dr. Charles K. Teter, Cleveland, Ohio.
Dr. E. I. McKesson, Toledo, Ohio.
Dr. Isabella C. Herb, Chicago, Ill.
Dr. Yandel Henderson of Yale University.

"The Travel Study Club of American Physicians, which made a successful study tour of Europe last year, has completed the plans for its 1915 study tour to the A. M. A. meeting in San Francisco, Honolulu, Japan, the Philippines, China, with optional return via Siberia and Europe (war permitting) or via Canada. This being the first party of American physicians ever visiting the far East and the new possessions of the United States, a most cordial welcome can be expected by authorities and members of the medical profession. The Travel Study Club would like to make its enterprises as representative as possible, and asks all those interested to communicate with the Secretary, Dr. Richard Kovacs, 236 East 69th Street, New York."

Obituary

Dr. William L. Dudley.

Dr. William L. Dudley, who, until a few years ago was dean of the Medical Department of Vanderbilt University, died suddenly September 8. Though Dr. Dudley had been in poor health for several years his sudden death came as a surprise to his many friends. He was born in Covington, Ky., in 1859 and graduated from the University of Cincinnati in 1880. He was a chemist by profession. He was professor of Chemistry at the Williams Medical College at one time; later he was professor of Chemistry at Vanderbilt. He was not only a good chemist but also a great teacher. His wide knowledge and thorough grasp of chemistry and allied branches of science was an inspiration to those who attended his lectures, and his personality was such that he was beloved by all who came in contact with him. His loss will be keenly felt not only by Vanderbilt University but by the entire community.

Reviews and Book Notices

"Progressive Medicine"—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics, Materia Medica, and Diagnosis in the Jefferson Medical College, Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, Etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Vol. III. September, 1914. Diseases of the Thorax and Its Viscera, including the Heart, Lungs and Blood Vessels—Dermatology and Syphilis—Obstetrics—Diseases of the Nervous System. Lea & Febiger, Philadelphia and New York, 1914.

Our thanks are due the publishers for this interesting volume of Progressive Medicine. Of all modern publications issued in quarterly form this is decidedly the most substantially valuable. It contains the cream of recent advances and discoveries in readily accessible form from contributors who are well known in their several departments as authoritative. The contributors to this number are Edw. P. Davis, M.D., William Ewart, M.D., F. R. C. P., Wm. S. Gottheil, M.D., and William G. Spitler, M.D. This number treats of Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood Vessels. Dermatology and Syphilis. Obstetrics. Diseases of the Nervous System. We have in reference to preceding numbers invariably commended this quarterly and we still think that every progressive physician should subscribe to the work.

"Diseases of Bones and Joints"—By Leonard W. Ely, M.D., Associate Professor of Surgery, Leland Stanford Junior University, San Francisco, Cal. Sextodecimo: 220 Pages, 94 Illustrations. Surgery Publishing Co., New York. Price, Cloth, $2.00.

The unusual interest now manifested by the profession in acute and chronic arthritis, as well as other forms of bone and joint diseases makes this book particularly timely.

Prof. Ely is particularly well equipped from experience to present an authoritative work, having specialized in this particular branch of surgery for years.

This book is intended primarily for the general practitioner, but instead of furnishing that long suffering and very important person with a mass of details, and with many methods of treatment from which he may choose, the book lays down broad general principles, with the evidence upon which they are based, and then shows how these principles may be applied.

In a brief, terse way, it presents the Anatomy, Physiology and Pathology of Bones and Joints, Acute and Chronic Arthritis of various types, Ankylosis, Diseases of the Shafts, Acute Osteomyelitis, Chronic Inflammations in the Bone Shafts, New Growths in Bone, etc.

The profuse photo-micographs with other illustrations aid materially in placing up to the eye of the reader the contents of the book and the marginal side-heads, printed in contrasting colors, permits of ready reference.

It is a book which will be much appreciated by the general practitioner and can be read with the assurance that it presents valuable instructions from an authoritative source upon a subject where much light is needed.

"Manual of the Diseases of the Eye"—For Students and General Practitioners. By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, New York, 1880-1903; Attending Ophthalmic Surgeon to the Mt. Sinai Hospital; Consulting Ophthalmologist to Bellevue Hospital, to the French Hospital, to the Red Cross Hospital and to the Italian Hospital, New York. Eighth Edition. Revised, with 377 Original Illustrations, Including 22 Plates with 75 Colored Figures. New York. William Woodard Co., 1914.

The number of editions through which this manual has run and the translations into foreign languages through which it has

undergone indicates the high value that has been placed upon the publication by the medical profession in this and in other countries. As a teaching manual of the important subject it is unexcelled, for the author has exercised a rare discrimination in using such material as is needed and excluding material of little practical use to the practitioner. It is a steppingstone to a fuller knowledge of the subject as may be obtained in more complete text-books and a practical guide to the physician whose time is too limited for searching for facts in the standard text-books upon the subject. We heartily commend the work to students and practitioners.

"Ambidexterity and Mental Culture"—By H. Macnaughton-Jones, M.D., M.Ch., I. U. I., M. A. O. U. I. (Hon. Can.), F. R. C. I. and Ed.; Ex. University Professor Queens University, Ireland; Honorary Member of the Societies of Obstetrics and Gynecology, Leipsic, Munich and Rome; Ex-President of the Obsteric and Gynecological Section of the Royal Society of Medicine, the British Gynecological Society and the Irish Medical Schools and Graduates Association. New York. Rebman Co. Herald Square Building, 141-145 West 36th St.

This small brochre is an amplification of a series of articles written by the author for "The Child." It is an interesting disquisition upon a subject that bears closely upon the education and training of the young.

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The little work should prove a valuable aid to prospective surgeons as the importance of ambidexterity in surgical operations is universally recognized.

Publisher's Department

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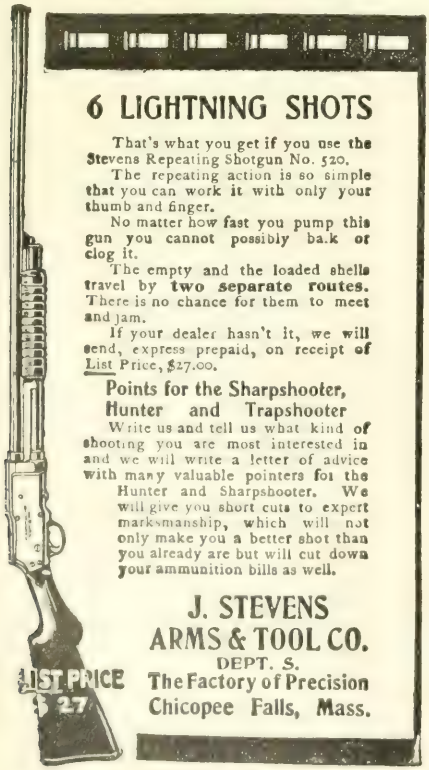

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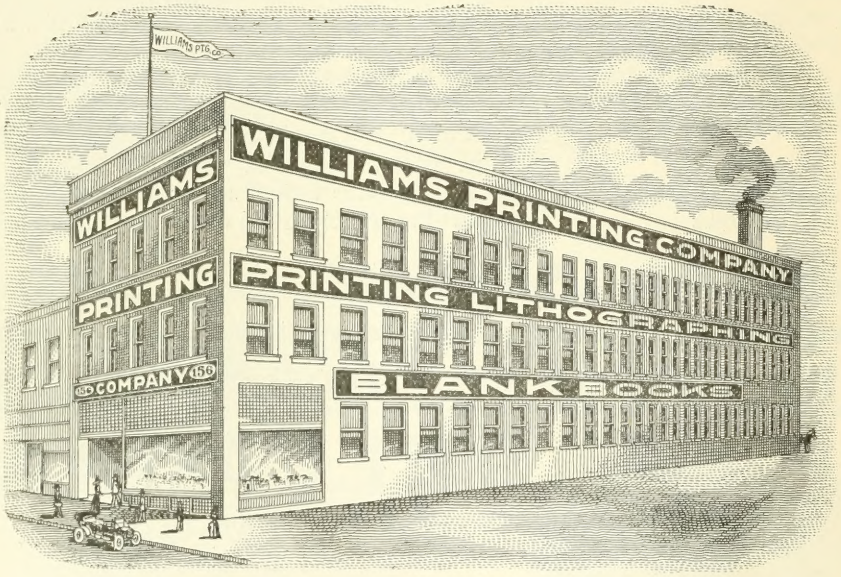

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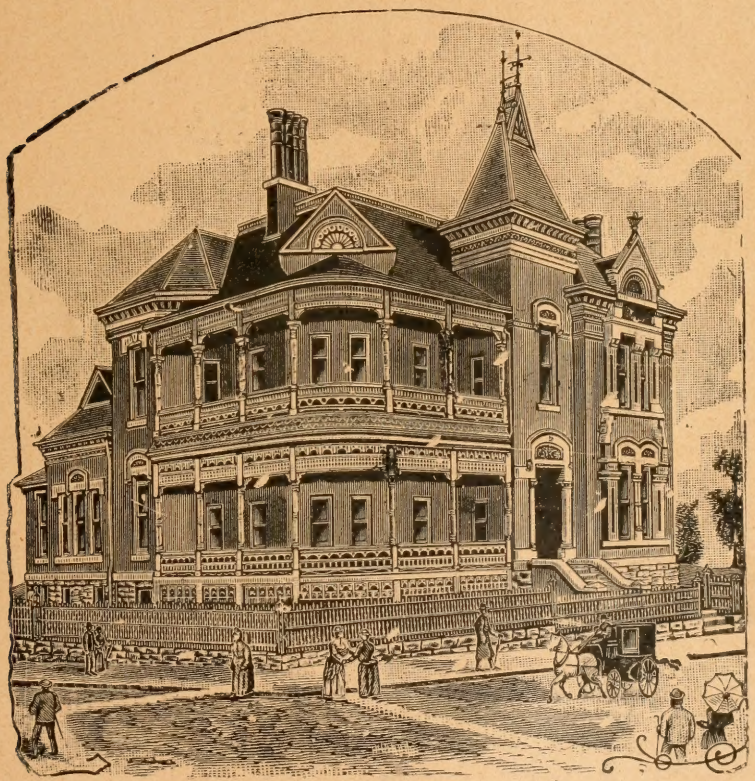

THIS INSTITUTION is located in the central part of the city, easily accessible by several lines of electric cars. Separate buildings for male and female patients, rooms well ventilated handsomely furnished and supplied with all the conveniences of modern hospital establishments. Excellent cuisine and competent trained nurses. The operating rooms are equipped with all the requisites of modern operative surgery. Rates of board reasonable. Twenty-Third season opens September 10, 1914. For further information address—

CHARLES S. BRIGGS, A. M., M. D.,

Or SAMUEL S. BRIGGS, M. D.,

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